STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155446	B. WIN	G		07/24/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	TER		/ILKIE DR WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
PREFIX TAG F000000	This visit was for Complaints INO and INO013273 Complaint INO0 Federal/state de allegations are of and F441. Complaint INO0 Federal/state de allegations are of and F441.	or the Investigation of 10131980, IN00132305, 5. 10131980-Substantiated. ficiencies related to the 10132305-Substantiated. ficiencies related to the 10132305-Substantiated. ficiencies related to the 10132735-Substantiated.	F00	PREFIX TAG	This Plan of Correction is the center's credible allegation of compliance. Preparation and/of execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alledged or conclusions set for in the statement of deficiencies. The plan of correction is prepand/or executed solely becautis required by the provisions of federal and state law.	or ne ts orth es. ared se it	DATE
	Survey team: Christine Fodre	a RN TC					
	Census bed type						
	SNF/NF: 115						
	Total: 115						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

861411 Facility ID: 000476

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155446		ILDING	00	COMPI 07/24			
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE		
	Census payor type: Medicare: 20 Medicaid: 68 Other: 27 Total: 115 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on July 31, 2013, by Brenda Meredith, R.N.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155446	B. WIN			07/24/	2013
			В. WП.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ΓER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000223 SS=D	483.13(b), 483.13 FREE FROM AB SECLUSION The resident has verbal, sexual, ph corporal punishm seclusion. The facility must sexual, or physic punishment, or in Based on interr review, the fact residents were abuse for 1 of 3 a sample of 7 (Findings includ Resident #S' re 7-23-2013 at 9 diagnoses includ limited to: depr pressure, and of Resident #S' 5 Set assessment 7-19-2013, india Brief Interview (BIMS) score of indicated Resid oriented and co appropriately. In an interview	the right to be free from hysical, and mental abuse, lent, and involuntary not use verbal, mental, all abuse, corporal evoluntary seclusion. View and record free from feelings of 3 residents reviewed in (Resident # S) le: ecord was reviewed: 30 AM. Resident #S' uded but were not ression, high blood osteoporosis. - day Minimum Data and (MDS), dated icated Resident #S had we for Mental Status of 13. The score dent #S was alert and buld answer questions	F00	0223	F 223- 1. Social Services/designee spoke to Resident # S regaurding her feelings Resident voiced she is happy to be that the facility. 2. All residents were interviewed to assure that they feel free from feeling of abuse. No other residents identified to be affected by deficiency. 3. Facility will do quarterly QA round interviewing residents during IDT walking rounds and asking residents they feel safe and free from feelings abuse. 4. The CMS form for Resident intervand observation will be utilized with IDT walking rounds. These rounds to be completed quarterly and upon admission to ensure residents are from feelings of abuse. Every reside that is interviewable will be interview at least every 30 days during IDT walking rounds and/or Angel Rounds These forms will be turned into Admin/designee and be reviewed monthly in QA and quarterly by the Medical Director for six months. 5. Facility will be compliant by Augu 23, 2013	gs ed s if of view the evill ee ent ed	08/23/2013
		dicated Resident #S d using a slide board.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUII B. WIN	LDING	00	COMPL: 07/24/	ETED		
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR ITER FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	AM, Resident # be transferred to 7-5-2013, CNA into the room to had the side both Resident #S to CNA #3 was at CNA #2 then pibefore CNA #3 the transfer or to Resident #S incomplete the floor, and the f	dicated her knees hit hought CNA #2 had oken her ankle. dicated she told CNA is she thought her leg esident #S further ould not remember if ked her leg, but she ay and everything was #S additionally ad increased pain						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLI	ETED
		155446	B. WIN			07/24/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	t		1	ILKIE DR		
COMING	TON MANOR HEAI	TH AND REHABILITATION CEN	ITER		VAYNE, IN 46804		
			IILIN		VATIVE, IIV 40004		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION SHOULD BE ACTION SHOULD			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ought CNA #2 had					
	broken her leg	. CNA #3 indicated the					
	nurse on duty	was alerted to the					
	allegation.						
	-						
	In an interview	on 7-23-20-13 at 1:52					
		dicated she had been					
	-	-2013 at about 2:30					
		2 Resident #S had					
	been transferre						
		NA #2 had broken her					
	•	ther indicated CNA #2					
		esident #S had not					
		the floor. LPN #4					
		assessed the leg					
	Resident #S w	as complaining was in					
	pain, but did no	ot see any changes,					
	and so nothing	further was done. LPN					
	#4 indicated R	esident #S told her she					
	had not fallen.	and so thought no					
		egation. LPN #4					
		eported the occurrence					
		t, and the next day					
		e in, the nurse giving					
		, ,					
	•	cated Resident #S had					
		being taken to the					
	•	se of left leg pain. LPN					
		sider the allegation to					
	be abuse.						
	The Medication	n Administration					
	Record (MAR)	, dated 7-2013,					
	` '	dent #S utilized as					
) pain medication on					
	• "	2 at 4 PM and 8 PM,					
	1 1 at 3 1 ivi, 1-	Z at + i ivi and 0 i ivi,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

If continuation sheet Page 5 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	COMPLI	
		100440	B. WIN			07/24/	2013
NAME OF PR	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COVINGT	ON MANOR HEAL	TH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		PM, then on 7-5 at 4		IAG	BELLOEI, CT,		DATE
		and 7-6 at 1:30 AM,					
	9:40 AM, and 1						
	0.40 / tivi, and 1	1-10 1 Wi.					
	Resident #S' no	urse's notes, dated					
		20 PM, indicated					
		een dropped, ice had					
	been applied to	the area, x-ray					
		cture, but due to					
	•	, Resident #S was					
	•	ed to the hospital					
	•	om for evaluation and					
		re were no nurse's 5-2013 available for					
I	review.	5-2013 available loi					
	Teview.						
	Review of the o	current policy titled					
		ion, Intervention,					
		and Crime Reporting,					
	dated Septemb	per 2011, provided by					
	the Administrat	or on 7-23-2013 at					
		cated: Any form of					
		f residents including,					
		to abuse, neglect,					
	•	oluntary seclusion, or					
	misappropriation	on is strictly prohibited.					
	2 1 27/5)						
	3.1-27(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DBIG	00	COMPL	ETED
		155446	A. BUII			07/24/	2013
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
000///01		THE AND DELIABILITATION OF NO			ILKIE DR		
COVING	I ON MANOR HEAL	TH AND REHABILITATION CENT	EK	FORTV	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000225	483.13(c)(1)(ii)-(ii	i), (c)(2) - (4)					
SS=D	INVESTIGATE/R						
	ALLEGATIONS/II	NDIVIDUALS					
	The facility must	not employ individuals who					
	have been found	guilty of abusing,					
	•	streating residents by a					
		ave had a finding entered					
		se aide registry concerning					
		nistreatment of residents or					
		of their property; and report					
		has of actions by a court of					
	_	nployee, which would					
		for service as a nurse aide					
		aff to the State nurse aide					
	registry or licensi	ng autnorities.					
	_	ensure that all alleged					
		ng mistreatment, neglect, or					
		injuries of unknown source					
		tion of resident property					
	are reported imm						
		he facility and to other					
		ance with State law					
		ed procedures (including to					
	the State survey	and certification agency).					
	The facility must be	have evidence that all					
	alleged violations						
	_	must prevent further					
	J ,	hile the investigation is in					
	progress.	Time the investigation is in					
	progress.						
	The results of all	investigations must be					
	reported to the ac	•					
	•	sentative and to other					
	-	ance with State law					
	(including to the S	State survey and					
		cy) within 5 working days of					
		if the alleged violation is					
		te corrective action must					
	be taken.						
	Based on inter	view and record	F00	0225	1.Unable to report incident.		08/23/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155446	B. WIN			07/24/2013
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	3			ILKIE DR	
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	NTER		WAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ility failed to ensure an			Anyone will be reported to the Administrator immediately and	
	_	ouse was reported to			reported to State per Federal	•
		tor for 1 of 3 residents			guidelines. Staff to be educate	ed
	reviewed in a s	sample of 7 (Resident #			ongoing throughout the month	I
	S)				and throughout the	
					year and yearly as required by	
	Findings includ	de:			Federal guidelines on how, whand who to report abuse	nen (
	Resident #S' re	ecord was reviewed			allegations to.	
		:30 AM. Resident #S'			Facility reveiwed last 30 da of grievances to ensure	iyə
		uded but were not			allegations of abuse were	
	_				reported timely. Administrator	
	-	ression, high blood			educated on guidelines for	
	pressure, and	osteoporosis.			reporting incidents.	
	D : 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				3. Administrator educated on	
		- day Minimum Data			guidelines for reporting incider Administrator/designee will rev	
		nt (MDS), dated			grievance logs monthly to ens	
	· ·	icated Resident #S had			allegations of abuse were	
		w for Mental Status			reported.	
		of 13. The score			4. Results will be forwarded to	
		dent #S was alert and			QA committee monthly for two	
	oriented and c	ould answer questions			months and then quarterly for months after. Admin/designe	
	appropriately.				conduct 5 random staff intervi	ews
	l In an interview	on 7-22-2013 at 8:45			weekly for 1 month, 1 time we for one month and then month	· •
		dicated Resident #S			for 4 months. Every resident t	, ,
	•	d using a slide board.			is interviewable will be	
	พลง และเอเธกร	a doning a shad board.			interviewed at least every 30 o	
	In an interview	on 7-23-2013 at 11:45			during IDT walking rounds and	d/or
		#S indicated she was to			Angel Rounds. 5. Facility will be compliant by	,
	·				August 23, 2013	
		by slide board, and on				
	7-5-2013, CNA #2 and CNA #3 came					
		o transfer her. CNA #3				
	had the side board. CNA #2 assisted					
		her side and face her.				
	CNA #3 was a	t Resident #S' back.				

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Event ID: 861411

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) N	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155446	B. WI			07/24/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	₹		5700 W	ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	NTER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	CNA #2 then p	oivoted Resident #S					
	before CNA #3	3 could assist her with					
	the transfer or	the side board.					
	Resident #S in	dicated her knees hit					
	the floor, and t	hought CNA #2 had					
	dislodged or b	roken her ankle.					
	_	dicated she told CNA					
	#2 and CNA #3	3 she thought her leg					
		esident #S further					
	indicated she	could not remember if					
	the nurse chec	cked her leg, but she					
		ray and everything was					
		#S additionally					
		nad increased pain					
	because she w	•					
		vas transieneu					
	improperly.						
	In an interview	on 7-23-13 at 1:34					
	PM, CNA #3 ir	ndicated she was in					
	Resident #S ro	oom with CNA #2 when					
	CNA #2 pivote	d Resident #S. CNA #3					
	indicated the p	ivot happened so fast,					
	she did not ha	ve time to tell CNA #2					
	to use the slide	e board. CNA#3 further					
		dent #S knees did not					
		, but Resident #S did					
		ought CNA #2 had					
		. CNA #3 indicated the					
	·	was alerted to the					
	allegation.						
	anogation.						
		on 7-23-20-13 at 1:52					
		dicated she had been					
	notified on 7-5	-2013 at about 2:30					
	PM, by CNA #	2 Resident #S had					

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Event ID: 861411

Facility ID: 000476

If continuation sheet Page 9 of 31

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155446			NSTRUCTION 00	(X3) DATE : COMPL 07/24 /	ETED	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
	been transferred, and was complaining CNA #2 had broken her leg. LPN #4 further indicated CNA #2 had told her Resident #S had not fallen or slid to the floor. LPN #4 indicated she assessed the leg Resident #S was complaining was in pain, but did not see any changes, and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. Review of the current policy titled Abuse Prevention, Intervention, Investigation, and Crime Reporting, dated September 2011, provided by the Administrator on 7-23-2013 at 10:42 AM, indicated: It is the responsibility of employees to immediately report to the Administratorany incident of suspected or alleged resident abuse from other residents, staff, family or visitors 3.1-28(c)						

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Event ID: 861411

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		(X2) M A. BU B. WII	ie survey ipleted 24/2013							
		LTH AND REHABILITATION CEI								
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			

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Event ID: 861411

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		(X2) MU A. BUIL B. WING	DING	ONSTRUCTION 00	(X3) DATE (COMPL 07/24 /	ETED	
	ROVIDER OR SUPPLIER	L TH AND REHABILITATION CENT	•	5700 W	ADDRESS, CITY, STATE, ZIP CODE VILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIVE ACTIV		TE	(X5) COMPLETION DATE
F000226 SS=D	ETC POLICIES The facility must written policies ar mistreatment, ne	MENT ABUSE/NEGLECT, develop and implement nd procedures that prohibit glect, and abuse of sappropriation of resident	F00	0226	Anyone will be reported to the		08/23/2013
	review, the factoric policy prohibiting implemented for reviewed in a second se	or 1 of 3 residents cample of 7 (Resident #			Administrator immediately and report to State per Federal guidelines. State educated ongoing throughout the month and throughout the year and yearly as required by Federal guidelion how, when and who to report abuallegations to. 2. All residents were interview to assure that they feel free free feelings of abuse. No other residents identified to be	ff to ines ise ved	
	Resident #S' record was reviewed 7-23-2013 at 9:30 AM. Resident #S' diagnoses included but were not limited to: depression, high blood pressure, and osteoporosis. Resident #S' 5- day Minimum Data Set assessment (MDS), dated 7-19-2013, indicated Resident #S had a Brief Interview for Mental Status (BIMS) score of 13. The score indicated Resident #S was alert and oriented and could answer questions appropriately.				affected. 3. Facility will do quarterly QA walking rounds interviewing residents and asking them if the feel safe and free from feeling abuse. Any situation identified an allegation of abuse will be reported to the Administrator at then reported to the State. 4. The CMS form for Resident interview and observation will utilized with the IDT walking rounds. Every resident that is interviewable will be interviewed at least every 30 days during I walking rounds and/or Angel Rounds. These rounds will be completed quarterly and upon admission to ensure residents free from feelings of abuse. A	ney s of d as and be ed DT are	
	AM, LPN #1 in	on 7-22-2013 at 8:45 dicated Resident #S d using a slide board.			reports of abuse will immediate be reported to the State. 5. Facility will be compliant by	ely	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	COMPI	
	155446	A. BU B. WI	ILDING NG		07/24	
NAME OF I	DRAVIDED AR CURRULER	D. 111		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			ILKIE DR		
COVING	TON MANOR HEALTH AND REHABILITATION CEN	ITER	FORT V	WAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	7	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
	,			August 23, 2013		
	In an interview on 7-23-2013 at 11:45					
	AM, Resident #S indicated she was to					
	be transferred by slide board, and on					
	7-5-2013, CNA #2 and CNA #3 came					
	into the room to transfer her. CNA #3					
	had the side board. CNA #2 assisted					
	Resident #S to her side and face her.					
	CNA #3 was at Resident #S' back.					
	CNA #2 then pivoted Resident #S					
	before CNA #3 could assist her with the transfer or the side board.					
	Resident #S indicated her knees hit					
	the floor, and thought CNA #2 had					
	dislodged or broken her ankle.					
	Resident #S indicated she told CNA					
	#2 and CNA #3 she thought her leg					
	was broken. Resident #S further					
	indicated she could not remember if					
	the nurse checked her leg, but she					
	did have an x-ray and everything was					
	fine. Resident #S additionally					
	indicated she had increased pain					
	because she was transferred					
	improperly.					
	In an interview on 7-23-13 at 1:34					
	PM, CNA #3 indicated she was in					
	Resident #S room with CNA #2 when					
	CNA #2 pivoted Resident #S. CNA #3					
	indicated the pivot happened so fast,					
	she did not have time to tell CNA #2					
	to use the slide board. CNA#3 further					
	indicated Resident #S knees did not					
	touch the floor, but Resident #S did					

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Event ID: 861411

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			07/24/2013
NAME OF P	ROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
					ILKIE DR	
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEI	NTER	FORT V	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ought CNA #2 had				
	_	. CNA #3 indicated the				
	•	was alerted to the				
	allegation.					
	In an interview	on 7-23-20-13 at 1:52				
		dicated she had been				
	·	-2013 at about 2:30				
		2 Resident #S had				
	been transferre					
		NA #2 had broken her				
		rther indicated CNA #2				
	_	esident #S had not				
	fallen or slid to	the floor. LPN #4				
	indicated she a	assessed the leg				
		as complaining was in				
		ot see any changes,				
	•	further was done. LPN				
	_	esident #S told her she				
	had not fallen,	and so thought no				
	more of the all	egation. LPN #4				
	indicated she r	reported the occurrence				
	to the next shif	t, and the next day				
	when she cam	e in, the nurse giving				
	her report indic	cated Resident #S had				
	•	s being taken to the				
		se of left leg pain. LPN				
	#4 did not consider the allegation to					
	be abuse.	-				
	The Medication Administration					
	Record (MAR) dated 7-2013 indicated					
	Resident #S ut	tilized as necessary				
	(prn) pain med	ication on 7-1 at 9 PM,				
	7-2 at 4 PM an	d 8 PM, on 7-3 at 5:30				

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Event ID: 861411

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155446	B. WI	NG		07/24	/2013
NAME OF B	DOWNER OF CLIPPLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	5 at 4 PM, and 8 PM					
) AM, 9:40 AM, and					
	1:40 PM.						
		urse's notes dated					
		20 PM indicated					
		een dropped, ice had					
	• •	the area, x-ray					
		cture, but due to					
		, Resident #S was					
	_	ed to the hospital					
		om for evaluation and re were no nurse's					
		5-2013 available for					
	review.	5-2013 available loi					
	Teview.						
	review of the c	urrent policy titled					
		ion, Intervention,					
		and Crime Reporting,					
	_	per 2011, provided by					
	•	tor on 7-23-2013 at					
		ated: Any form of					
		f residents including,					
		to abuse, neglect,					
		voluntary seclusion, or					
	•	on is strictly prohibited.					
		ner indicated It is the					
	responsibility o						
	immediately re	• •					
	,	any incident of					
		lleged resident abuse					
	•	dents, staff, family or					
	visitors	,					
	3.1-28(a)						

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Event ID: 861411

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	22 201112011011	155446	A. BUILDING B. WING		07/24/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		/ILKIE DR	
COVING	TON MANOR HEA	LTH AND REHABILITATION CENT		WAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG	REGULATORT OR	LISC IDENTIFTING INFORMATION)	TAG		DATE

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Event ID: 861411

Facility ID: 000476

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155446	B. WIN			07/24/	2013
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER	FORT V	WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEI ICIERCI)		DATE
F000309 SS=D	HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial well the comprehensiv care. Based on interreview, the fact surgical wound drainage for 1 with wounds in (Resident #T) Findings include Resident #T's in 7-24-2013 at 1 #T's diagnoses limited to: high diabetes, and of (Gastroesopha) Admitting nurse indicated Resid with a midline a approximately Assessment fu colostomy was 3 centimeters fo Resident #T's a	ist receive and the facility necessary care and or maintain the highest cal, mental, and libeing, in accordance with we assessment and plan of view and record fility failed to ensure a liwas free of colostomy of 3 residents reviewed a sample of 7. Ite: Tecord was reviewed 0:36 AM. Resident included but were not blood pressure, GERD Geal reflux disease). Tele's assessment dent #T was admitted abdominal incision 18.6 centimeters long. There indicated a located approximately from the incision on abdominal incision.	F00	0309	1.Resident T no longer resides in the facility. 2. All residents that have colostomy and wounds were reviewed in the facility. No other issues were noted with residents with colostomy and wounds 3. In servicing has started with licens staff on colostomy and colostomy procedures and this will be ongoing Licensed staff were in serviced on wound vacs on July 26 th and July 2 by webinar with KCI. Ongoing education to continue. 4. All resident with the colostomy and wound vacs will be monited by DON/designee on random shifts to assure the colostomy and the wound vac are applied properly Monitoring will be 5x/week for month and then weekly for 1 month and then monthly for six months. Results will be review at QA monthly and reviewed by the MD on a quarterly basis. 5. Facility will be compliant by August 23, 2013	sed 9 th my pred ne y. 1 x ved y	08/23/2013
	Nurse's notes, PM, indicated I	dated 7-7-2013 at 2 Resident #T's					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	ILDING	00	COMPL	ETED
		155446	B. WIN			07/24/	2013
			b. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	ILKIE DR		
COMING.	TON MANOR HEA	LTH AND REHABILITATION CEN	TED		VAYNE, IN 46804		
COVING	- TON WANOK HEA	ETTI AND REHABIEITATION CEN	ILIX	TOKTV	VATNE, IN 40004		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	colostomy was	leaking into the wound					
	bed. The notes	s further indicated					
	attempts to rec	dress the wound was					
	unsuccessful.						
	In an interview	on 7-24-2013 at 11:29					
		dicated Resident #T's					
	1	difficult to manage, order for stomahesive					
		and the colostomy					
		adhere easily to the					
	skin. LPN #5 ft	urther indicated she					
	had informed h	ner supervisor, but no					
	help had been	given.					
	-						
	In an interview	on 7-24-2013 at 1:48					
		dicated the stool from					
		was sucked into the					
	I -	ssing. LPN #6 further					
		asked her supervisor					
		•					
		with the colostomy, but					
	no assistance	had been given.					
		on 7-24-2013 at 1:37					
	PM, RN #7 ind	licated she had not					
	been aware Re	esident #T's colostomy					
		ing into the wound and					
		prevent further wound					
		should have been					
		#7 further indicated					
		d have charted any					
		-					
	intervention the	ey altempted.					
	3.1-37(a)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEI	FICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORR	RECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155446	B. WING 07/24/2013				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDE	R OR SUPPLIER				ILKIE DR		
COVINGTON MA	ANOR HEAL	TH AND REHABILITATION CENT	ER		VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	ACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG REC	GULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155446		LDING		07/24/	2013
		.001.10	B. WIN			0.72.	_0.0
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
111111111111111111111111111111111111111	no (iben on bollen	•		5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ΓER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000441	483.65						
SS=D	INFECTION CON	ITROL, PREVENT					
	SPREAD, LINEN						
		establish and maintain an					
	•	Program designed to					
		anitary and comfortable					
	•	to help prevent the					
		transmission of disease					
	and infection.	transmission of disease					
	ana imedian.						
	(a) Infection Cont	rol Program					
	· ·	establish an Infection					
	Control Program						
	•	controls, and prevents					
	infections in the fa						
		procedures, such as					
		be applied to an individual					
		be applied to all individual					
	resident; and	and of incidents and					
	· ·	ecord of incidents and					
	corrective actions	related to infections.					
	(b) Preventing Sp	read of Infection					
	(1) When the Infe	ection Control Program					
	determines that a	resident needs isolation to					
	prevent the sprea	nd of infection, the facility					
	must isolate the r						
	(2) The facility mu	ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or					
		t contact will transmit the					
	disease.	e contact viii a anomit ano					
		ust require staff to wash					
		each direct resident contact					
		ashing is indicated by					
	accepted profess						
	accepted profess	ισται ριασίισο.					
	(c) Linens						
		nandle, store, process and					
	•	o as to prevent the spread					
	of infection.						
	Based on obse	rvation, interview and	F00	00441	1.Staff was in serviced July 25, 2013		08/23/2013
		the facility failed to			and continue to be in serviced ongoi	ng	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLE	ETED
		155446		LDING		07/24/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
00) (1) (0		I THE AND DELIABILITATION OF N	TED		ILKIE DR		
COVING	TON MANOR HEAD	LTH AND REHABILITATION CEN	IEK	FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ensure used gl	loves were disposed of			on proper disposal of gloves and soi	led	
	properly in one	room reviewed and			linen. 2. All rooms have been observed an	.	
		s disposed of properly			any dirty linens or gloves were to be		
		eviewed, this had the			removed immediately. No other		
		ect 2 residents on the			residents identified to be affected.	,	
	•				Staff was in serviced July 25, 201 and continue to be in serviced ongoi		
	,	ident #S and Resident			on proper disposal of gloves and soil		
	#R)				linen.	.	
					All staff will monitor that gloves a soiled linen will be disposed of	nd	
	Findings includ	le:			properly. Angel Rounds to include		
					monitoring of soiled linens and glove	es in	
	1. Resident #S	s' record was reviewed			resident rooms 5x/week on random		
		:30 AM. Resident #S'			shifts during rounds. This monitoring take place daily for 1 month, weekly		
		uded but were not			1 month and then monthly for 6	101	
	_				months. Results will be reviewed at		
	•	ression, high blood			monthly and reviewed by the MD on	а	
	pressure, and	osteoporosis.			quarterly basis for six months. 5. Facility will be compliant by Augu	ıst	
					23, 2013		
	During an obse	ervation on 7-23-2013					
	at 10:25 AM, a	glove, inside another					
	glove turned in	side out was observed					
	_	in the resident room.					
	, ,	towel with a partially					
	•	ot on it was observed					
	-						
	in a chair on to	ip of a pillow.					
		7 00 0040 / 10 00					
		on 7-23-2013 at 10:26					
		idicated the glove					
	should have be	een thrown away in the					
	trash and the to	owel should have been					
	placed in the d	irty linen.					
		, -					
	2. Resident #R's record was reviewed						
	7-22-2013 at 2:32 PM. Resident #R's						
	_	uded but were not					
	•	ression, diabetes, and					
	osteoarthritis.						

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Event ID: 861411

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN			07/24/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
00/41/10		THE AND DELIABILITATION OF A	TED		ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	IEK	FORTV	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	2:10 PM a tower spot covering a observed on Restand. In an interview AM, Resident # linen was often more than one Resident #R's completed quance Set (MDS) date her Brief intervial (BIMS) score was spot covered to the complete of the comp	most recently rterly Minimum Data ed 6-13-2013 indicated iew for mental status vas 15 indicating as alert and oriented					

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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER IXAI ID SIMMARY STATIMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESETX TAG REQUILATIONY CARS DEINITHYNG IN NORMATION) TAG REQUILATIONY CARS DEINITHYNG IN NORMATION) TAG REQUILATIONY CARS DEINITHYNG IN NORMATION) THE facility must provide a safe, functional, sanitary, and combinable environment for residents, safef and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room) This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:33 AM, the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation. SIRREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE OR FORT WAYNE, IN 46804 STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE OR FORT WAYNE, IN 46804 STATE ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE OR FORT WAYNE, IN 46804 SAFETY AND	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER SIMMARY STATIMINAT OF DEPICEINCES PREFIX TAG REGULATORY OR ISC IDENTIFYING PROPARATION) SAFE, FUNCTIONAL/SANITARY/COMFOR The facility must provide a safe, functional, sanitary, and comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:33 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was measured at 77 degrees. When the air conditioner was shocked, the compressor would not turn on despite manipulation. STREET ADDRESS, CITY, STATE, ZIF CODE STREET, ZI	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OF SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER (RACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OF LISC DENTIFYMOUN INFORMATION) TAG REGULATORY OF LISC DENTIFYMOUN INFORMATION TAG TAG REGULATORY OF LISC DENTIFYMOUN INFORMATION TAG REGULATORY OF LISC DENTIFYMOUN INFORMATION TAG TAG TAG TAG TAG TAG TAG TA			155446				07/24/2013	
COVINGTON MANOR HEALTH AND REHABILITATION CENTER (AS) ID PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) SAFE/FUNCTIONAL/SANITARY/COMFOR TRABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation.				B. WIN	_	ADDRESS CITY STATE ZID CODE		
COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X3) ID SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE PREEDED BY PULL REGILATORY OR LSC IDENTIFYING INFORMATION) TAG FROM 483,70(h) SS=F FOR WAYNE, IN 46804 (X5) COMPLETION REGILATORY OR LSC IDENTIFYING INFORMATION) The facility must provide a safe, functional, sanitary, and confortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable rorn temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation.	NAME OF P	ROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MIST BE PRECEDED BY FILL. TAG REGULATORY OF ISC (DENTETYNS) INFORMATION) TAG REGULATORY OF ISC (DENTETYNS) INFORMATION) TAG REGULATORY OF ISC (DENTETYNS) INFORMATION) TAG REGULATORY OF ISC (DENTETYNS) INFORMATION TAG REGULATORY OF ISC (DENTETYNS) INFORMATION TAG REGULATORY OF ISC (DENTETYNS)	COMPC.		TH AND DEHABILITATION CENT	TED				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LARGE INFO	COVING	TON MANOR HEAL	I'H AND REHABILITATION CEN	IEK	FURIV	WATNE, IN 40004		
TAG REGULATORY OR ISC IDENTIFYING INFORMATION) TAG REGULATORY OR ISC IDENTIFYING INFORMATION) TAG REGULATORY OR ISC IDENTIFYING INFORMATION) TAG 483.70(ft) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation.	(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
FOOD465 SS=F FOOD465 SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation.	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX		ΓE	COMPLETION
SS=F SAFE/EVINCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a comfortable environment in 2 of 5 resident rooms reviewed for comfortable room temperatures on a sample of 7. (Room of Resident #R and Confidential Room)This had the potential to affect all residents residing in the facility. Findings include: 1. Resident #R's record was reviewed 7-22-2013 at 2:32 PM. Resident #R's diagnoses included but were not limited to: depression, diabetes, and osteoarthritis. During an environmental tour on 7-22-2013 at 9:38 AM, the air conditioner in Resident #R's room was observed to be on, and air coming from the air conditioner was measured at 77 degrees. When the air conditioner was checked, the compressor would not turn on despite manipulation.	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
In an interview on 7-22013 at 9:38 AM, the Maintenance Director	F000465	483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must person sanitary, and commercial record review, maintain a commin 2 of 5 residence comfortable roces ample of 7. (Frand Confidential potential to affer residing in the firm of the facility of the fac	NAL/SANITARY/COMFOR National provide a safe, functional, infortable environment for and the public. Ervation, interview and the facility failed to infortable environment introoms reviewed for om temperatures on a Room of Resident #R al Room)This had the facility. The interview and the facility failed to infortable environment introoms reviewed for om temperatures on a Room of Resident #R al Room)This had the facility. The interview and the facility failed in the facility	F00		1. Maintenance replaced Resident R PTAC Unit and ensured the PTAC w working properly by checking the temperatures in the room. 2. All PTAC units were inspected by Maintenance. No other units were identified to have any issues at this time. 3. Maintenance or designee to add preventative maintenance logs and monitor on a monthly basis 4. Administrator will review preventa maintenance logs monthly in QA and the Medical Director quarterly in QA 6 months. 5. Facility will be compliant by Augu	to to d by for	

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Event ID: 861411

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN	IG		07/24/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLVEIE			5700 W	ILKIE DR		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the the	nermostat on that air					
	conditioner wa	s not working. He					
	further indicate	ed the air conditioners					
	had been chec	ked on the previous					
	Friday.						
	In an interview	on 7-22-2013 at 12:15					
	PM, Maintenar	nce worker #9 indicated					
	he had checke	d and cleaned the air					
	conditioner filte	ers on all the units. He					
	further indicate	ed he had checked the					
	compressors, a	and knew the					
	compressor on	Resident #R's unit					
	was not operat	ing, but because he					
	was cleaning tl	he filters, he didn't take					
	the time to prol	blem solve the					
	compressor pro	oblem. He additionally					
		were no preventative					
		ecords to review					
	regarding how	often the air					
		nits in the individual					
	rooms were ch						
	2. In a confider	ntial interview on					
		:05 PM, a family					
		ted there had been					
	repeated issue						
	-	ner mother's room. The					
		further indicated she					
		issue with the nurses,					
	but nothing had	·					
		a boott done.					
	3.1-19(h)						
	0.1-19(11 <i>)</i>						

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Event ID: 861411

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155446	(X2) MULT A. BUILDIN B. WING		00 	COMPL 07/24	ETED	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 861411

Facility ID: 000476

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00			ETED
155446		B. WIN			07/24/	2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			ILKIE DR		
COVINGTON MANOR HEALTH AND REHABILITATION CENT			TER		WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000514	483.75(I)(1)						
SS=D	RES						
		IPLETE/ACCURATE/ACCE					
	SSIBLE						
	•	maintain clinical records on					
		accordance with accepted					
		dards and practices that					
		curately documented; e; and systematically					
	organized.	e, and systematically					
	organizoa.						
	The clinical record must contain sufficient information to identify the resident; a record						
	of the resident's a	assessments; the plan of					
	care and services	s provided; the results of					
	• •	n screening conducted by					
	the State; and pro	_					
	Based on inter	view and record	F00	0514	1 Administrator informed Social		08/23/2013
	review, the fac	ility failed to ensure			Services that any concerns brought the SSD will be put on grievance for		
	accurate docur	mentation for 3 of 7			reviewed and forwarded to the	115,	
	residents revie	wed for documentation			appropriate department head to add	ress	
		7. (Resident #R,			the concern.	L	
	•	nd Resident #T)			2. Unit Managers will be in serviced August 8, 2013 that they will review	by	
	Resident #3, a	na Resident #1)			pertinent charting is complete and		
					identify any other high risk residents		
	Findings includ	le:			No other residents were identified to affected by this deficiency.) be	
					DON/designee will audit UMs on		
	 Resident #R 	s record was reviewed			5x/week to ensure that pertinent		
	7-22-2013 at 2	:32 PM. Resident #R's			charting and high risk residents are		
	diagnoses inclu	uded but were not			being documented on. 4. DON/designee will monitor		
	-	ression, diabetes, and			1x/day for a month, 1x		
	osteoarthritis.				weekly/month and quarterly fo	r	
	ootoodi tiiittis.				six months. Results		
	In an interview	on 7 00 0010 of 0:04			will be brought to QA committee	е	
		on 7-22-2013 at 3:34			and reviewed monthly for six		
	•	ndicated Resident #R			months.		
	had been offer	ed an different room			5. Facility will be compliant by		
	when her air co	onditioner was not			August 23, 2013		
	working proper	ly, but Resident #R					
	refused the roo	•					
	. 5.4554 116 100		ı				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
155446		A. BUI	ILDING	00	07/24/		
		100440	B. WIN			011241	2013
NAME OF	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITFR		ILKIE DR VAYNE, IN 46804		
					77 (TTLE, IIV 1000)	- 1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAU	A review of Reservices notes were available 3-13-2013 date. In an interview AM, the SSD (indicated she contest after the medical record the notes. 2. Resident #S 7-23-2013 at 9 diagnoses inclimited to: depressure, and In an interview AM, Resident 3 be transferred 7-5-2013, CNA into the room to the side by Resident #S to CNA #3 was a CNA #2 then postore CNA #3 the transfer or Resident #S in the floor, and to dislodged or by Resident #S in the sident #S in the s	sident #R's Social indicated no notes for review after the e. on 7-23-2013 at 10:12 Social Service Director) could not locate any 3-13 date, and s was unable to locate ' record was reviewed :30 AM. Resident #S' uded but were not ression, high blood		IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETED					
		155446	B. WIN	G		07/24/20	013
NAME OF P	PROVIDER OR SUPPLIEI	· {		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CE	NTER	FORTV	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	1	DATE
ı	was broken. Resident #S further indicated she could not remember if						
		cked her leg, but she					
		ray and everything was					
	fine. Resident	nad increased pain					
		vas transferred					
	improperly.	ของ แต่ก่อเซกซน					
	iniproperty.						
	In an interview	on 7-23-13 at 1:34					
		ndicated she was in					
	· ·	oom with CNA #2 when					
		d Resident #S. CNA #3					
	•	ivot happened so fast,					
	•	ve time to tell CNA #2					
		e board. CNA#3 further					
		dent #S knees did not					
		, but Resident #S did					
		ought CNA #2 had					
		. CNA #3 indicated the					
	_	was alerted to the					
	allegation.						
	In an interview	on 7-23-20-13 at 1:52					
	PM, LPN #4 in	dicated she had been					
	notified on 7-5	-2013 at about 2:30					
	PM, by CNA #	2 Resident #S had					
	been transferre	•					
	complaining C	NA #2 had broken her					
	•	rther indicated CNA #2					
	had told her R	esident #S had not					
	fallen or slid to	the floor. LPN #4					
	indicated she a	assessed the leg					
	Resident #S w	as complaining was in					
	pain, but did n	ot see any changes,					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 24/2013
	PROVIDER OR SUPPLIER STON MANOR HEALTH AND REHABILITATION CENT	STREET 5700 V	ADDRESS, CITY, STATE, ZIP O WILKIE DR WAYNE, IN 46804	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	and so nothing further was done. LPN #4 indicated Resident #S told her she had not fallen, and so thought no more of the allegation. LPN #4 indicated she reported the occurrence to the next shift, and the next day when she came in, the nurse giving her report indicated Resident #S had fallen, and was being taken to the hospital because of left leg pain. LPN #4 did not consider the allegation to be abuse. Resident #S' nurse's notes, dated 7-6-2013 at 6:20 PM, indicated resident had been dropped, ice had been applied to the area, x-ray showed no fracture, but due to increased pain, Resident #S was being transferred to the hospital Emergency Room for evaluation and treatment. There were no nurse's notes dated 7-5-2013 available for review. In an interview on 7-23-2013 at 1:48 PM, LPN #8 indicated incidents should be charted in the nurse's notes. 3. Resident #T's record was reviewed 7-24-2013 at 10:36 AM. Resident #T's diagnoses included but were not limited to: high blood pressure, diabetes, and GERD				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155446		B. WING			2013	
		L	D. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	₹			ILKIE DR			
COVINGTON MANOR HEALTH AND REHABILITATION CENT			NITED					
COVING	TON WANCE HEA	LIH AND REHABILITATION CE	NIEK	FORTV	VAYNE, IN 46804			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(Gastroesophe	eageal reflux disease).						
	Admitting nurs	e's assessment						
	_	dent #T was admitted						
		abdominal incision						
		18.6 centimeters long.						
		ırther indicated a						
		located approximately						
	3 centimeters t	from the incision on						
	Resident #T's	abdominal incision.						
	Nurse's notes	dated 7-7-2013 at 2						
	PM, indicated							
	•							
		leaking into the wound						
		further indicated						
		dress the wound was						
	unsuccessful.							
	In an interview	on 7-24-2013 at 11:29						
	AM, LPN #5 in	dicated Resident #T's						
	· ·	difficult to manage,						
	,	order for stomahesive						
		and the colostomy						
		•						
		adhere easily to the						
		urther indicated she						
	had informed h	ner supervisor, but no						
	help had been	given.						
	In an interview	on 7-24-2013 at 1:48						
	PM. LPN #6 in	dicated the stool from						
		was sucked into the						
	,							
		ssing. LPN #6 further						
		asked her supervisor						
	for assistance	with the colostomy, but						
	no assistance	had been given.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) N	IULTIPLE CO	ONSTRUCTION	COMPL	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			ILDING	00	07/24/	
	100440	B. WIN			01/24/	2010
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
00\/IN0	COMMOTON MANOR LIENTIL AND RELIABILITATION CENT			ILKIE DR		
COVING	TON MANOR HEALTH AND REHABILITATION CENT	IEK	FORT	VAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	┼	TAG	DEFICIENCY)		DATE
	In an interview on 7-24-2013 at 1:37 PM, RN #7 indicated she had not been aware Resident #T's colostomy had been leaking into the wound and interventions to prevent further wound contamination should have been attempted. RN #7 further indicated the staff should have charted any intervention they attempted. 3.1-50(a)(1)					

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